FINANCING OF HEALTH CARE – THE EXPERIENCE OF VOLUNTARY HEALTH SERVICES

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PART II – FINANCING OF HEALTH CARE – THE EXPERIENCE OF VOLUNTARY HEALTH SERVICES.

WORKSHOP ON HEALTH CARE FINANCING
ORGANISED BY VOLUNTARY HEALTH ASSOCIATION OF INDIA/
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PART I

ABOUT VOLUNTARY HEALTH SERVICES AND ITS COMMUNITY HEALTH CARE PROGRAMMES

The Voluntary Health Services Medical Centre (VHS) is a comprehensive community hospital housing all the specialities and superspecialities except cardio-thoracic surgery and maternity at present. The medical centre has all the modern facilities expected of a referal hospital including preventive, promotive, diagnostic, curative and rehabilitative services.

The VHS was registered as a non-profit society on July 14, 1958. The in-patient services commenced from the year 1963.

Right from the inception, the VHS has been modelled to deliver comprehensive and continuous health services having several concepts which are unique not only in the delivery of services but also in the matter of financing of health care in the country.

The main concepts of Voluntary Health Services are:

i. Prevention and Cure of serious illness

The first concept of the society is that in a country with so many preventable diseases, and deaths, the emphasis should be on prevention of serious illness to the comparative exclusion of minor or day-to-day illness. It is felt that the latter can be handled by the large number of public dispensaries and unaided private practitioners who are welcome to utilise the services of the Medical Centre.

ii. Family as a Unit

The second concept is that the family should be the unit for medical care and that every family should be attached to a combined public health and curative centre and should learn about all diseases and their prevention from the same Social Worker, Health visitor or Public Health Nurse attached to the Medical Centre to which the family knows it belongs.

iii. Community Participation

One of the many ways in which the community participation is secured is by enrolling families in the different income groups as subscribers to the Medical Aid Plan.

iv. Maintenance of family health records

It is absolutely essential to have a comprehensive and continuous record of the medical and health history of each member of the family from birth. This health information system will go a long way in the provision of continuous and quality services and ensure proper follow up.

The most unique feature of the VHS is that, every brick is donated by individual donors, trusts and societies. The VHS has been supported by the successive Tamil Nadu State and Central Governments in the form of bed maintenance and support to individual projects. The entire society is functioning with the concept of 'Shram Daan' and if it is what it is today, is due to the cumulative efforts of several medical and para medical workers ably supported by several philanthropists.

I. GENERAL SERVICES

1. Medical Aid Plan: The services to the families are rendered through a medical aid plan which is a unique pre payment concept which has been formulated to popularise sharing of the burden of maintenance of one's own health care by the families, as they do for their own food, clothing and shelter. Under this plan, families will have to become subscribers by paying a nominal subscription for the entire family at the rate of 0.75% of their annual income. Families earning below Rs. 300/- per month need not have to pay any further charges for OP and IP care which includes free diet. Subscribers above this income level will have to pay graded charges on a sliding scale even for which a concession of 25% is available.

Services are not refused to those who do not want to become subscribers. Though they may not get the concession eligible for subscribers, the charges for these categories are moderate when compared to the market rates. Even here there is a gradation in the charges.

2. Out-patient Department: A well equipped O.P. for all departments including indigenous systems of medicines, functions in two well laid out buildings.

As soon as a family becomes a subscriber, the health records of all the members of the family are maintained by compulsory examination. By this method, we are able to uncover the hidden ice berg of diseases. The services start with preventive measures like inocculations, nutrition advice and health education. Based on the findings of the

examination, OP and IP care is given as per exigencies of the condition. The families are encouraged to bring the other members of the family for compulsory examination. Other services in the form of examination of Blood Pressure, Urine analysis and 70 mm X-ray chest are also offered for early detection of Hypertension, Diabetes and Tuberculosis.

3. Day Care Centre: The day care centre, donated by M/s Larsen & Toubro,is a new concept in the health care process. There are several trivial conditions which do not necessitate admission for longer periods in IP set up. Conditions like Diarrhoea, vomiting, minor surgical and medical conditions can be kept under observation and treated at the OP department itself. Such a measure not only reduces the load on the IP services but also cuts down the cost and the record work.

4. In-patient Services: We have 240 inpatient beds of which 60% are for poor patients. This includes 19 beds in Deluxe special wards and 18 beds for paying patients in A and B class special wards.

The general medical and surgical departments cater to all types of medical and surgical problems including emergencies. Individual departments are also conducting research programmes. The wards and rooms are large and airy with a minimal risk of cross infection. This has been appreciated by several national and international visitors. The Surgical Department is backed by three well equipped and air conditioned theatres.

II. SPECIALISED SERVICES

1. Intensive Care Unit: With kind munuficience of T.S. Srinivasan (Cheema) of M/s. Sundaram Clayton, this unit caters to the medical and surgical emergencies and has modern equipments for resuscitation and continued monitoring.

2. Neurosurgery: The Achanta Lakshmipathy Neurosurgical Centre has won national and international recognition. This department not only provides clinical and diagnostic services of excellence but also conducts research in several areas like Epilepsy, Yoga and nonvolitional Bio-feed back etc.

3. Neurology Department: The K. Gopalakrishna Department of Neurology has been specialising in the diagnosis and treatment of neurological disorders and has become well noted for the comprehensiveness of approach. Several international visitors have appreciated the quality of its work. Special emphasis is being paid by this department for the study,

control and rehabilitation of stroke patients and muscular dystrophy.

4. Nephrology: The Bhagavan Adinath Jain Department of Nephrology has been donated by Shri. Sugalchand Jain. Though this department has been started recently, it has made giant strides in a very short time. It is doing very useful work to the community by undertaking renal dialysis and has so far successfully completed 30 renal transplants in collaboration with surgical and urological services of the VHS. The unique feature of these services is the low cost for dialysis and transplants.

5. Urology: This department has modern equipments and is conducting routine and trans-urethral surgery. This unit collaborates actively with the department of Nephrology for renal transplants.

6. Diabetic Department: From the modest beginning in 1965, when only OP services were available, the T.G.K. Raman Diabetic Department has grown into a centre of excellence and now as a Ramabadran Research Laboratory is doing pioneering work in the detection and control of diabetes with a special emphasis on research on juvenile diabetes.

7. Cardiology: This department conducts routine clinical, diagnostic and curative work in collaboration with the community health department. The J. Srinivasan Cardiac Research Wing has been studying the problem of causal factors associated with coronary thrombosis in the City of Madras.

8. Psychiatry: The usual psychiatric services including counselling, diagnostic and curative services including ECT therapy are provided in this department. The main emphasis is on community psychiatry.

9. Dermatology: Routine dermatology services are available in this department.

10. Gynaecology: Routine gynaecological services are being provided at this department.

11. ENT: This department was built through the munificience of Madras Round Table No.I and has been doing pioneering work in the treatment of deafness through Stapedectomy. This centre was nurtured and developed by Dr. V.S. Subramaniam. To this, is attached the Venky's department, donated by Mr.V. Arunachalam. It is doing work on deafness among school children and advising appropriate management.

12. Opthalmology: This department supported by R.R. Iyer Charities and Shri. V. Sundaram, gives routine ophthalmological services. Cataract surgery including intra-ocular lens implantation is being undertaken at this department.

13. Orthopaedics: This department is undertaking routine orthopaedic services and is specialising in partial hip replacement and spinal surgery.

14. Leprosy: The VHS is attending to several leprosy patients living in and around Adyar directly. In addition, through its project aided by USAID through Government of India for control of Leprosy and Tuberculosis. it is taking care of about 2000 leprosy patients living in the adjacent parts of the Chingleput district. This unit treats the leprosy patients using the modern multi drug regimen. The patients having ENL reactions, ulcers and those requiring reconstructive surgery are admitted in the leprosy inpatient block.

Leprosy Research: For the past few years, the VHS is involved in the laboratory culture of M. Leprae. At present, various synthetic media are being studied by Dr.N. Veeraraghavan for the speedy culture of the organism in the laboratory. In addition, this department is testing out new combination of durgs using the concept of cell Mediated Immunity.

15. Tuberculosis: The VHS is a recognised peripheral health institution of the Tuberculosis centre at Madras. The unique feature of this department is the low defaulter rate when compared to the other similar facilities elsewhere consequent to the assured follow up services to the cases through the community health care programme.

16. Geriatrics: The VHS is first among the agencies to have thought about the need for provision of Geriatric services especially in a society where values are changing fast. Towards this end, the VHS through the kind courtesy of several philanthropists and Helpage has constructed eight geriatric cottages and two dormitories for the care of the elderly. Provision for cooking is available at the geriatric cottages. There are attractive schemes for the continued geriatric care on both short and long term basis.

17. The Urban Family Welfare Centre: This centre is serving a population of 25,000 living in slums adjacent to the medical centre. This has recently been upgraded as an Urban Health Post under the World Bank Assisted India Population Project V. The VHS believes in family welfare services being

part and parcel of comprehensive health care programme instead of a vertical approach.

18. Diagnostic Centre: Jadavbai Nathmal Singhvee Diagnostic Centre donated by Shri. Sugalchand Jain undertakes all types of clinical, bio-chemical and histopathologic investigations. The reports of this centre are accepted by the medical profession as authentic. Research work is being done for culture of M. Tuberculosis using Veeraraghavan's medium, in addition to other microbiological research. A unit of diagnostic centre is functioning at Luz, Mylapore.

19. Radiology: The department has three X-ray machines with screening facilities donated by CARE, Government of India/Arogya ashrama samithi and USAID.

20. Endoscopy Centre: It is a full fledged centre with modern equipments for doing upper gastroscopy, retroduodenoscopy, proctocolonoscopy, bronchoscopy investigations. It goes a long way in the early detection of ulcers, malignancies and multi tissue diagnosis. The cost for these investigations is very low. This has been made possible by the donation from Jindal Aluminium Company.

21. Blood Bank: Dr. K.S. Ranganathan Blood Bank has won laurels for its original studies regarding the Rh factor and for propagation of the voluntary blood donation. This centre can aptly be described as the Father of Voluntary Blood Donation Movement in India.

22. Physiotherapy: This department has all facilities for traction, heat treatment and exercises therapy for both orthopaedic and neurological problems.

III. TRAINING

The Voluntary Health Services believes in undertaking job oriented training for medical and paramedical workers. It has been our view that we cannot afford to train medical and para medicals for UK and USA. The entire training must be directed towards tackling the day-to-day problems which these categories will encounter.

The following training programmes are being undertaken at the VHS:

1. For the Grass-root level workers: These are middle aged women identified from the community with a basic educational qualification of 8th standard. They are trained as Lay First Aiders. They act as informants of the health events in the

village to the Multipurpose Workers, in addition to providing first aid during times of need.

2. Multipurpose Workers: An Eighteen Months training programme for Multipurpose Worker (Female) candidates who have passed 10th Standard is undertaken. This training is recognised by the Tamil Nadu Nurses and Midwives Council. The annual intake of candidates for this course is, two batches of ten each.

Multipurpose Training Programme for males of one year duration is also being conducted.

3. Training programme for Non-medical Graduates: Non-medical graduates are eligible for admission to one year P.G. Diploma Course recognised by the Government of Tamil Nadu in the following three disciplines:

i. Medical Laboratory Technology
ii. Nutrition and Dietetics
iii. Health and Hospital Administration

4. Post-graduate Training of Medical Officers: The VHS is recognised by the National Board Examination for the award of the degree of diplomate of National Board in the following disciplines:

General Medicine,
General Surgery,
Neurosurgery,
Community Health,
Family Medicine,
Social and Preventive Medicine and
Health Administration.

5. Others: In addition to the above, several training programmes are organised for:

Postgraduate doctors from National Institute of Nutrition;
M.A. students of Madras School of Social Work; Stella Maris College;
Nava Nirmana, Madras; P.S. Senior Secondary School
Orientation training to students and doctors from Ramachandra Medical College, Madras and Centre for Development studies, Ulloor, Trivandrum.

This institute has undertaken the responsibility for conducting examinations for the Nursing Assistant students from Khajamalai Ladies Association and Holy Cross Convent Association, Trichy.

IV. RESEARCH PROGRAMMES

The Voluntary Health Services does not believe in undertaking sophisticated research of little practical relevance. On the other hand, it actively promotes research, directed towards the commonly prevailing problems in the community.

V. ALTERNATIVE SYSTEMS OF MEDICINE

Though the institution is devoted to modern medical care, VHS has been encouraging the growth of alternative systems of medicine. The Achanta Lakshmipathy Centre for research in Ayurveda and Siddha is the centre of excellence for research in those branches. This centre has won a number of gold medals for its original research. The VHS also has got centres for magneto-biology, Acupuncture etc. The acupuncture training was given to doctors of VHS and outsiders by Chinese team of experts in Acupuncture.

VI. COMMUNITY HEALTH

The VHS from the beginning has been modelled as a community hospital intended for taking care of the community living in areas adjacent to it. With this area concept in view, the community health department was one of the first departments to be started.

The Mini Health Centre model for the delivery of comprehensive health services at a low cost was evolved after a series of operational experiments to work out the ideal population coverage and the staff to be deployed. These experiments were conducted at the St. Thomas Mount Community Development Block of Chingleput District in the mid-sixties. Dr. K. S. Sanjivi and Dr. K. Venkateswara Rao are the authors of these concepts and experiments.

In the late 1960s the model of the Mini Health Centres took shape and were put on ground in some rural areas of Chingleput District of Tamil Nadu State.

The ideal set up for Mini Health Centre as evolved is:

a) A health post manned by Lay First Aider for every 1000 population.
b) A male and a female Multipurpose Worker for every 5000 population.
c) A doctor being available at the Mini Health Centre (MHC) level for at least three hours a day on three days a week.

d) The identification of, and liaison with, a referal hospital within a reasonable distance.

In the mini health centre, the family is the unit of care. The essential concept is that, every family should set apart a small amount within its ability to pay towards the health care as it does for its food, clothing and shelter.

Dr. Sanjivi believes that health cannot be delivered in a neat gift packet. It is essentially 'a do it yourself' proposition in which every one should participate.

Health alone cannot stand in isolation. It is essentially a part and parcel of socio-economic development. The ideal combination of socio economic development and medical technology will ensure better primary health care.

There is an increasig tendency of the politicians to medicalise the socio economic problems. Health care programmes will not be meaningful until and unless a strong base is laid by the political will and bureaucratic support in association with the enabling and empowering process of the community aimed at ensuring better community participation.

The first and foremost activity in the mini health centre is to determine the target groups for the various health activities by taking a numerical count of the people living within the jurisdiction of the mini health centre. This enumeration is done having the family as a unit for purposes of identification and comprehensiveness of coverage and follow up.

The families are enrolled as subscribers in the prepayment plan. The amount of subscription paid varies according to the income status of the family. It amounts to 0.75% of the annual income. Enrolment as subscriber will entitle the family to receive curative care and services at the referal institution without their having to pay further subscription. The preventive and promotive care is given to all inhabitants in the mini health centre area irrespective of their membership status. The Curative care is provided to non subscribers also but after receiving a fee per service.

We believe in checking up all the individuals in a family once a year as a routine measure to detect the hidden problems. By this approach, we find that more than 95% of the population require some type of assistance or the other. The people may not readily come forward to seek medical assistance unless the suffering caused by the illness prevents them from earning their livelihood. In a programme

aiming at prevention, this approach will go a long way in avoiding the development of chronic and intractable problems.

Family folders are maintained and the complete medical and developmental history of all the members of the family is entered in these folders. This, we believe, is very important for the development of health information system and for ensuring the continuity of follow up.

The Primary Health Care system starts at the remote villages at the hands of the Lay First Aider manning the health post. This LFA is always a middle aged woman who acts as an health informant and communicates the health events to the multipurpose workers. In addition,she will also visit the houses to know the current health status, as well as for follow up, to ensure professionals at the Mini health centre. She also provides basic medicines at times of need at her health post.

a. Maternal Services

Based on the information provided by Lay first aiders,pregnant mothers are registered and followed up by routine antenatal care until the delivery.

Disposable Delivery Kit is provided to each pregnant mother to be given to the birth attendant during the time of delivery. Skilled assistance is provided for the conduct of aseptic deliveries. The health workers liaise with the Traditional Birth Attendants and give training to them in the conduct of safe and aseptic deliveries. High Risk mothers having previous bad obstetric histories, severe anaemias and other medical problems are referred to the hospital.

b) Child Health Services

The children are assured of total protection against vaccine preventable diseases as per the prescribed time schedule. Growth of the children is monitored regularly. Nutritional supplements are provided to children of Grade III malnutrition. Appropriate nutritional supplements are also given to pregnant mothers during the last trimester to combat the problem of low birth weight.

The mothers are educated about the oral rehydration therapy in the prevention of morbidity and mortality following diarrhoea. Preparation of sugar and salt solution is demonstrated to them in the health education sessions.

Periodic deworming is attempted to improve the health status of children.

Health check up for school children is an important activity of the mini health centre in the area.

c) Control of Communicable Diseases:

Prevention of communicable diseases as an integral part of the comprehensive health services is a sheet-anchor of the mini health centre activities. Consequent to the regular house visiting, screening for malaria, leprosy, tuberculosis and other communicable diseases, becomes a routine. Sputum cups are distributed to all the symptomatics. The sputum smear is fixed and examined for the presence of Tubercle bacilli. Then suspected cases are taken to the referal hospital for an X-ray for the detection of radiologically positive cases. After confirmation, the patients are put on domiciliary treatment on standard regimens. The patients are regularly followed up for control and treatment default and examined at prescribed intervals to assess the progress of treatment.

All the cases suspected to be having a patch are examined for the presence of anaesthesia and treatment offered at the door steps without much publicity to avoid their social stigmatisation. The patients are put on modern multi-drug regimen. Microcellular rubber shoes are distributed to the leprosy patients to prevent trophic ulceration.

d) Family Welfare:

Target couples are identified from among the eligible couples for family planning advice and services. Conventional Contraceptives and oral pills are distributed at the door steps. IUD insertions are also done at the local areas and cases requiring sterilisation are referred to urban family welfare centre attached to Voluntary Health Services.

e) Laboratory Support:

Laboratory support is available at the local and at the referal hospital levels.

f) Registration of vital events

Vital events such as births and deaths are identified and registered with the Village Administrative Officer.

g) Environmental Sanitation

Bad environmental sanitation and bad personal hygiene are the root causes for the spread of communicable diseases. Though it is realised that ideal environmental sanitation is closely linked to socio economic development, as a short term interim measure, the community is encouraged to dig soakage pits for the drainage of waste water. They are advised on the disposal of garbage in the compost pit and the usage of sanitary latrines. These facilities are demonstrated at the Environmental Sanitation demonstration plot at the model health cum training centre in Thuraipakkam Mini Health Centre.

h) Health and Nutritional Education

Health education is a regular activity in the mini health centre. In addition to person to person approach, group discussions and audio visual shows are conducted.

Nutrituion education is provided for the usage of locally available food stuffs and in the preparation of low cost weaning foods. Regular nutrition demonstration sessions are organised at the village level. Weaning food packets are available at subsidised rates with Lay First Aiders. These foods are very popular with the villagers.

Seeds for the development of kitchen gardens are distributed free of cost to the community. The emphasis is on the growth of dark green leafy vegetables.

i) Curative Care

The medical officer conducts clinics at the headquarters of the mini health centre on two days a week and on the third day they conducts clinic at one of the villages served by that mini health centre by turns, to ensure greater peripheralisation of health care as well as for providing 'on the spot' health education and follow up.

In our experience, it has been found that slightly more than 92% of the medical problems can be dealt with at the mini health centre level itself. Only 8% require referal to an institution for higher level diagnosis and care. A mere 1.5% of the total disease load requires actual in-patient care.

j) Referal Chain

The poor villager is not exempt from getting serious and chronic ailments. In the event of such an occurrence,

the health care system must rise up in providing the best possible care as is available for their urban counterparts. The acute problems that arise at the health posts, should be in the hands of the physicians or surgeons at the referal hospital within three to four hours and the cold problems within a week.

We believe that, families in a defined geographical area must be attached to an identified referal hospital through the mini health centres, instead of, their being made to seek medical and health care through institutions based on their employment.

The Voluntary Health Services with its specialities and super specialities, is the referal hospital for all the mini health centres in the area and provides tertiary support to the rural health posts/mini health centres.

The mini health centre scheme envisages the laying on ground of an ideal referal system on an area concept. In our programme, even the lay first aider can refer medical problems which in her opinion require higher medical attention. The referal hospital has been instructed to give priority attention irrespective of the time of the day even though they appear trivial in nature to the medical officers at the referal institution to maintain the credibility of the village level workers.

k) Community Participation

The mini health centre scheme emphasises community participation which is three fold. The community provides accommodation and minimal furniture.

A non political local action committee is constituted for a two way liaison between service providers and the beneficiaries. There is financial participation by the community in the form of subscriptions or fee for service.

l) Urban Health Care

As already stated, health care of the people living in urban slums is also considered a priority. In addition to all the problems faced by their rural counterparts, the urban slum dwellers are prone to more air and noise pollution and accidents. They also suffer from higher degree of mental trauma due to the gap between anticipation and achievement. The urban health care model evolved by the Voluntary Health Services is currently being implemented in several urban slums of Madras City by several voluntary organisations.

m) Financing

Both the Central and State Governments have solicited voluntary organisation to supplement governmental efforts, as no country in the world can afford to provide total health care all by itself. The successive governments both at Tamil Nadu and at the Centre have encouraged our concepts and schemes. Currently, the expenditure for running a mini health centre is being shared on a 1:1:1 basis by the Central Government, the State Government and the Community.

We believe that if 0.75% of our GNP is available as a part of community contribution by way of supplementation of governmental spending, health care services can be organised in a planned manner through the community health and educational development combines.

n) Achievements of Community Health Project of VHS

	1977	1989
Crude Birth Rate	39.7/1000 pop.	21.4
Crude Death Rate	16.9/1000 pop.	7.0
Infant Mortality Rate	134/1000 LBs	36.5
Couple protection rate	Could not be ascertained	40.2
%of immunisation coverage among eligible children & AN mothers	2	80
% of antenatal registration of pregnant women	Negligible	94
% of deliveries conducted by trained health workers	8	40
% of mothers receiving postnatal care	Negligible	90
% of children covered by child welfare services	5	80

These achievements of our mini health centres within a short span of a decade reveal that there has been measurable impact on the overall health status of the community served by the project as evidenced by the reductions in the birth, death and ifant mortality rates and the other parameters regarding the provision of various services.

There cannot be any further proof for the success of the scheme beyond the fact that 261 mini health centres are functioning in Tamil Nadu on the pattern evolved by the Voluntary Health Services.

Mini health centre scheme has been commended by the Planning Commission and World Bank. Several National and International organisations and visitors have shown keen interest in the programme.

o) Replication

India is also a signatory to Alma Ata Declaration. Mere declarations, slogans, Working Groups, Task Forces, Workshops, Symposia, Seminars and Discussions will not produce the desired result. It is only the concrete plans of action at the grass root level that can yield specific results. The Voluntary Health Services firmly believes that the mini health centre model if replicated throughout the country will not only result in making the comprehensive health services available at the doorstep of the family but also generate the much needed additional resources thereby ensuring community participation.

Several physical and operational targets have been prescribed for achieving Health For all by 2000 AD by the Government of India. We strongly believe that if our approach is adopted, these targets can be achieved much earlier than the scheduled date.

The Voluntary Health Services strongly believes that organisation of mini health centres in the private sector is not at all difficult. If sufficient number of voluntary organisations is not available, the local bodies can play the role of voluntary agency. The service organisations like the Lions and Rotaryclubs, instead of conducting adhoc camps,medical camps and project reliefs, should underwrite mini health centres which ensure permanancy of the service and their name.

VII. M.A. CHIDAMBARAM INSTITUTE OF COMMUNITY HEALTH

The M.A. Chidambaram Institute of Community Health, which is a unit of VHS supported by the M.A.C. Educational and Medical Foundations is totally devoted to---

a. Development of low cost Alternative approaches to Primary Health Care.
b. Research into the commonly prevalent community health problems of the day.
c. Training of health manpower for the meaningful delivery of health care programmes.
d. Consultancy for the propagation of community health concepts.

The model health cum training centre at Thuraipakkam has become a trend setter for several national organisations, individual societies and trusts.

PART II

FINANCING OF HEALTH CARE-THE EXPERIENCE OF VOLUNTARY HEALTH SERVICES

A. GENERAL OBSERVATIONS ON FINANCING OF HEALTH CARE IN INDIA

The Financing of Health Care in our country can be discussed under the following heads:

--- Central
--- State
--- Jointly by Central and State
--- Organised Sector
--- Private
--- a. Purely Private
  i. Private practitioners
  ii. Nursing Homes
  iii. Private Hospitals
    --- Five Star
    --- Three Star

b. Purely voluntary
c. Voluntary aided by Government
d. Spending by individual families
e. Health Services by industries

While it may be possible to get data for the Central, State, Jointly Central and State sectors and organised Sectors for knowing the level of expenditure it is difficult to study the private spending consequent to:

a. Number of service out-lets
b. Non standard pattern of expenditure
c. Confidentiality of expenditure
d. Miscellany of activities

Health expenditure of private individuals can only be guessed. There are various determinants for private expenditure:

a. The number of individuals having illness
b. The episodes of illness
c. Types of illness
d. The place of re-dressal
e. The individual providing attention, logistics etc.

The health expenditure in the various five year plans as a percentage of total public sector outlay is indicated below:

Period	Health	Family Welfare	Total
1st Plan (1951-56)	3.3	-	3.3
2nd Plan (1956-61)	3.0	0.1	3.1
3rd Plan (1961-66)	2.6	0.3	2.9
Annl.Plan (1966-69)	2.1	1.1	3.2
4th Plan (1969-74)	2.1	1.8	3.9
5th Plan (1974-79)	1.9	1.3	3.2
1979-80	1.8	1.0	2.8
6th Plan (1980-85)	1.9	1.0	2.9
7th Plan (1985-90)	1.9	1.8	3.7

A perusal of the table reveals that financial allocation for the health sector as a percentage of the overall public sector outlay has never been more than 4%. In US it is 10.81% of their much higher income of the total government expenditure; in Australia it is 9.99%. Even in Kenya and Mauritius it is more than 7.0% and in Burma it is 6.96%.

Per capita expenditure

Calculating the percapita expenditure on health by simple arithmetic is obviously a misleading information. According to Planning Commission the per capita expenditure on health has been 46.23 and on Family Welfare 7.19. As 80% of the health services are in the urban areas, 80% of the

expenditure naturally goes to urban areas and a greater proportion of this goes to the maintenance of multimillion, chromium plated, ivory tower institutions.

The following table highlights the percapita expenditure of Maharashtra State:

Total - Rs. 156 million

3 cities	Bombay - Rs. 14.6		
	Poona - Rs. 12.17	80.0%	
	Nagpur - Rs. 6.09		
District towns ..		6.2%	
Other Miscellaneous centres		9.3%	
Villages		4.5%	

A perusal of the table reveals that in the rural areas a mere 13 paise is available per person.

Break-down of Health Rupee

A perusal of the expenditure pattern indicates that more than 85% of the expenditure goes to maintenance of staff and only 14% goes to drugs. The question that crops up is - how much of this expenditure really results in accrual of benefit and of what kind to the ultimate recipients of the services for whom the entire health hierarchy exists.

Is it possible for the benefits to be quantified in economic terms?

Will a mere increase in the allocation of rupees and consequent increase in the per capita health expenditure result in tangible benefits in terms of reduction of morbidity and mortality? If yes for how long ?

The determining factors seem to be minor ailments which keepon recurring, Higher threshold for suffering; Low priority to Health. What would be the proportional costing of Health rupee ? - Salaries Vs Services/Benefits, Preventive Care Vs Curative Care.

B. FINANCIAL ASPECTS OF VOLUNTARY HEALTH SERVICES

I. <u>Sources of income</u>

There are five major sources of revenue of which the single largest is through direct patient collections, It accounted for 55.6% of total income in the calender year 1989. Other sources of income were, government grant 17.5%; interest earnings 5.7%; private recurring donations 0.5% and miscellaneous receipts 4.8%; deficit 15.8%. The funding sources are described in detail below:

1. Patient collections

These include actual cut of pocket collections made from patients. They can be differentiated into three main types.

i. collections from the Medical Aid Plan Scheme
ii. service user charges and
iii. revenue generated from commercial schemes

Each is described in turn.

i. Medical Aid Plan (MAP)

It was conceived along the lines of a voluntary health insurance scheme. Pre-payment to the plan was to be made by clients in anticipation of the need for health services. The annual premia per household is graded according to joint monthly income. The income categorization and corresponding membership fee is as follows:

Group	Income	Subscription amount
F	Below Rs. 300/-	Rs. 24/-
PIII	Rs. 301/-750/-	Rs. 50/-
PII	Rs. 751/-1500/-	Rs. 100/-
PI	Rs. 1501/-3000/-	Rs. 200/-
NS	Rs. 3001/-and above	Rs. 400/-

Membership to the scheme entitles all household members to a free annual health checkup. Curative and diagnostic services for both out-patient and in-patient services are offered at concessional rates to members. Assessment of income has always been a challenge.

Evidence of socio-economic status is got in the form of an income certificate from those in formal employment and a ration card from those in the casual sector.

The task of income assessment is difficult and sometimes traumatic one, and that there is a tendency on the part of patients to cheat whilst declaring their incomes.

Almost 70 to 80% of members are in the lowest socio-economic group, those earning Rs. 300/- or less a month. The number of members in each category renewing their subscription during the year is low. This suggests that most members enrol only at the time of an episode of illness when they require health services.

ii. Service user charges

Fees are levied for all direct personal services. There is a two tier tariff schedule, where charges are graded firstly on the basis of whether there is membership to the MAP scheme, (which entitles the patient to concessional health care), and secondly according to income. There is thus, a sliding fee scale for both subscribers and non-subscribers of MAP.

At out-patient department, general consultation is provided free of charge to all subscribers of MAP. Non-subscribers are charged for both general and specialist consultations. All out-patients are charged for drugs at full cost plus a 10% mark up, except for a few basic drugs which are provided to the lowest income group at a nominal charge.

Fees for diagnostic investigations, such as X-ray and laboratory tests are graded by MAP membership and income.

There is an admission charge of Rs. 10/- for all in - patients, this is a flat rate regardless of the length of stay. Deluxe Unit patients are charged an admission fee of Rs. 20/-.

Subsequent in-patient care, including food, for members in the lowest MAP income group('F') is free of charge. Most patients earning less than Rs. 300/- per month join the MAP on admission. Other categories of patients (both subscribers and non-subscribers) are charged per item of service, fee levels are graded to income and membership. Fees are levied for: bed and medical attendance, operations, diagnostic investigations and other services. The pricing strategy on drugs is identical to the outpatient department, i.e., 110% of cost. All categories of patients are charged the same amount, with the exception of the 'F' group.

Pricing Strategy

Fee levels are set on the basis of an initial market survey of comparable services in the private sector. For example, for fixing a fee for a chemical pathology test, the prices charged by closely located competitors are investigated. Voluntary Health Services sets an identical fee, or slightly lower, to be competitive, as their fee for the highest income group in the non-subscriber category. This charge is then gradually reduced for lower income groups and MAP members. There has to be an appreciable difference between the two fees scales of subscribers and non-subscribers for the necessary incentive to join the MAP scheme.

Fees are revised periodically using the same technique and rationale.

iii. Income (revenue) generating schemes

Voluntary Health Services is operating several enterprising schemes which have the sole aim of income generation.

They are:

a. **The Deluxe Unit** - This is comparable to a private nursing home. Patients are charged commercial rates for rent and extra medical attendance. They are charged for all other services utilised at the highest rate in the non-subscriber category. The majority of Deluxe residents are private patients of the doctors serving at VHS under honorary status.

b. **"A" and "B" class wards** - These are special category wards of Madras Race Club (MRC) hospital. They are smaller in size than the general wards and they offer more private facilities. There are eight beds of "A" class and twelve beds of "B" class in the hospital. These are available to all non "F" group patients who are willing and able to pay for them. Bed charges are graded to income and MAP membership.

c. **Diagnostic Centre-Mylapore** - This is located in rented premises a few kilometers from the hospital. The centre conducts laboratory investigations for neighbouring private practitioners and individuals. Charges are at commercial rates.

2. Donations

Voluntary Health Services receives donations from private individuals, companies and charitable organisations. Subscription collections for Society membership are also included in this category. Donations are both capital and recurrent, although in the previous year there were no capital donations. Most donations are earmarked for specific health activities.

A third category of donation is received 'in-kind', that is not in direct money terms. A substantial in-kind donation is the voluntary service of many of the doctors. There are a number of part time medical officers who are paid a conveyance allowance only and some medical officers receive no compensation whatsoever for their services, they are accorded honorary status.

3. Interest on deposits

Voluntary Health Services currently possesses nine lakhs worth of endowments which are invested in fixed deposits. The interest earned from these comprise a

substantial proportion of total income. These, like recurrent donations, are usually earmarked for specific activities.

4. Government Grant

The Government of Tamil Nadu has accepted the responsibility of contributing to the bed-maintenance costs of the MRC hospital. This is subject to a bed ceiling of 240 and a cost ceiling per bed day of 15 rupees. The annual grant is disbursed in four instalments, the fourth being paid on submission of the annual audited accounts. This disbursement procedure leads to considerable delays which often results in payments in arrears of six months or more.

The State Government also meets, in part, the maintenance costs of Family Planning cases including drug and supply costs. There is a similar delay in grant disbursement.

In addition to recurring costs, the VHS gets building and equipment grant on 50:50 basis subject to a ceiling of Rs.30 lakhs.

II. Cost Structure

Total expenditure of VHS hospital and medical centre in 1989 was 41.67 lakhs, which was distributed amongst the major heads as follows:

Establishment	44.2%
General Administrative expenses	1.4%
Repairs and Renewals	4.5%
Sundries and Linen	10.9%
Consumable and Services	7.2%
Utilities	9.5%
Drugs	19.4%
Diet	2.9%.

Cost Components

1. Establishment Charges

Establishment costs consume the largest share of the budget at Rs.41.67 lakhs.

The above figure does not include the imputed cost of donated medical staff time. The full time salaried staff at VHS are receiving wages considerably lower than equivalent government employees. As an example, the wage bill for full-time doctors at VHS is estimated to Rs.1.5 lakhs below its equivalent government salary level.

2. General Administrative Costs

This expense head includes printing and stationary costs, postage and telegram, freight, cooly and conveyance allowance, advertisement charges, bank and overdraft costs, audit fee, subscription and miscellaneous expenses.

3. Consumable and Services

Under this head, are costs of X-ray and chemicals, blood transfusion charges, medical gas, fuel gas, washing charge and ambulance expenses.

4. Utility expenses

This includes electricity and telephone charges.

5. Diet

This head includes the cost of feeding `F' group patients and the few non `F' group patients who request food.

C. FINANCIAL ASPECTS OF MINI HEALTH CENTRE SCHEME

I. Sources of Income

Under the Government of Tamil Nadu pattern, the Mini Health Centres get 2/3rds grant i.e., Rs.18,000/- (Rs.9,000/- from Centre, Rs.9,000/- from State Government). The VHS share (Rs.9000/-) comprises, Mini Health Centre (MHC) collections, interest earnings, donations in cash and kind, the shortfall in the cash contribution is met by miscellaneous receipts.

Mini Health Centre collections are of two types:

i. The Medical Aid Plan (MAP) subscriptions
ii. Non subscriber user charges.

The Mini Health Centre MAP scheme is similar in concept to the Hospital and Medical Centre plan. Pre-payment to the plan entitles members to concessionary or free health care. Free service entitlement at the Centre includes health record maintenance, Doctor and Multipurpose Worker consultation, drugs and referal to the hospital, free outpaient and in-patient care. The scheme enrolment fees are identical to those of the hospital and are similarly graded by income. The majority of MHC members are in the lowest income category, earning less than Rs.300/- a month. Total membership in each centre is low. There is great resistance to join the scheme, unless there is need for referal treatment at the hospital. This may be a reflection of the community's willingness to pay for curative care which shows

tangible results and not for preventive care where the benefits are not so easily identifiable. VHS has found the task of selling the concept of insurance a difficult one.

II. Cost Structure

Under the government funded scheme the annual estimated budget of each centre is subject to a cost ceiling of Rs.27,000/-. The estimated distribution of costs under various expense heads is shown below:

Annual Budget per Mini Health Centre:

2 MPWs (@ Rs.400/- per month)	9,600/-
3 LFAs (@ Rs.50/- per month)	1,800/-
Drugs in LFA kit	600/-
Doctor (part time) @ Rs.300/- per month	3,600/-
Drugs at Mini Health Centre	6,000/-
Supervision, contingencies	3,600/-
Provision for accommodation	1,800/-

D. FACTORS CONTRIBUTING TO THE SUCCESS OF VHS - WITH PARTICULAR REFERENCE TO GENERATION OF REVENUE

1. Board of Trustees

The affairs of VHS is overseen by a Board of Trustees consisting of eminent individuals, industrialists and philanthropists. The Accountant/Auditor General of Government of Tamil Nadu is a member of the Board of Trustees. This Board plays a paternalistic watchful role.

2. A Strong Central Committee

The general direction for conducting the affairs of the institution comes from a Central Committee of both elected and nominated members. The nominated members represent large donors whereas the elected members are drawn from cream of medical professionals, businessmen and those in other professions. The members of this committee, in addition to giving broad direction help to a certain extent in locating sources of resources, for tapping.

3. Charisma of Individuals

The success of VHS to a large extent is due to personalities, notable among whom is Dr. K.S. Sanjivi. The individual consultants like Dr. Murali, Dr. B. Ramamurthi and others have also contributed in no less a measure not only for the attraction of resources but also in the matter of utilisation of the facilities as well.

4. Good accounting system

The accounting system of the VHS has been flawless and has contributed to a large extent in instilling confidence among various donors - institutional, individual and governmental, that the money donated is properly accounted and utilised for the purposes for which it has been given, keeping the overheads low.

5. Openness

The VHS has been absolutely open in receiving ideas and in contributing to the growth of similar organisations elsewhere in the State. The approaches, the flexibility and the humaneness have been the hall-marks of success.

6. Lack of bureaucratisation

The voluntary spirit has to be inhibited by one and all once they have agreed to serve the institution. Sacrifice is universal in the campus and only the degree varies. The entire administration at the top level is by a system of understanding and mutual love. Even today, after twentysix years of establishment we do not have an administrative manual or a detailed charter of delegation of powers.

The decision regarding staff matters are taken in a spirit of understanding. Anybody can approach anybody else in the organisation without inhibition.

7. Administrative and Academic freedom

The top level professionals of the institute are attracted for service because of the administrative and academic freedom they normally enjoy.

8. Income Tax exemptions

The success of VHS to a large measure is due to Income Tax exemption provided to individual donors, institutions, trusts, and foundations. Two types of Income Tax exemptions are available. For research oriented programme 100% exemption under 35, 1(ii) is available and for other donations 80G facility is available.

9. Honesty in approach

The Philanthropy that has been generated is singularly based on the honesty in approach of the administration. The records of VHS are open and can be scrutinised by any one and this frankness has been appreciated by one and all. Whatever little we are able to pay our staff we pay in full inspite of non receipt of grants etc. in time as a rule.

10. Dedicated and committed staff

The dedication and the commitment exhibited by the core group of the professionals and para professionals is another source of strength to the VHS.

11. Poor pay-scales

The low establishment charges are due to poor pay-scales when compared to similar categories in Government service. Though we began with Government scales, we are unable to keep pace with governmental scales due to obvious reasons.

12. Shram Dān

Majority of staff are working in an honorary capacity, getting a so called conveyance allowances which in affect in a lighter vein amounts to radiator water allowance. As already stated, the Shram Dan is universal in the campus, only the degree varies. Because of the voluntary nature, the over heads of several items like drugs, linen, laundry, stores, electricity, telephone are comparatively less due to economy of expenditure.

13. System of control

The inventory control at various levels though manually done help in the reduction of costs and unnecessary waste of resources and also avoids blockage of resources.

14. Government Support

The success of the VHS cannot be as what it is today but for the support extended to it, by successive Governments at the State and Central levels. The Tamil Nadu Government gives a bed-maintenance grant of Rs. 15/- a bed per day. In addition, it also gives 50% of the capital expenditure subject to a ceiling.

E. THE DRAWBACKS

1. Turnover of staff

Due to poor pay scales and due to young age, the lower categories of staff work for a short time, while awaiting for a Government job or for a job better prospects. This is even more in the case of the projects undertaken by the VHS, consequent to lack of job security.

2. Lack of finance for further expansion

Though the VHS has got a number of ideas for making available health care services within the reach of the

common man and it has got both land and infrastructure facilities for further growth; lack of adequate finance hampers its enthusiasm for rapid expansion. Nevertheless the VHS has expanded through dedicated work aided by philanthropy.

3. Thinning away of committed people

The old band of committed and dedicated workers is thinning away due to attrition by age and death. Though a majority among the younger generation do not lack in honesty and sincerity, due to the pressures of day to day life and rising costs, the ability of people for continually doing dedicated and committed services without meaningfull returns is causing a problem.

4. Not being able to keep pace

As Medical science is expanding rapidly and more and more sophisticated gadgets are becoming available, the VHS is not able to keep pace with the five star hospital culture. VHS realises that most of the gadgets may not be necessary for purposes of diagnosis of a majoraty of illnesses. Due to a process of comparison the referral organisation gets singled out by not possessing them.

5. Thinning of philanthropy

The main handicap is the inadequacy of financial resources available and this inadequacy is increasing continuously because private charity is being spread too thinly over an ever increasing number of voluntary organisations. It is obvious therefore that the voluntary organisations can play a very vital part in the reconstruction of health care, if the three principal assets are recognised and developed to the full and if their principal handicap is obviated through special financial assistance.

6. Impact of corporate/organised sector

Because of the advertisement technology and different value orientation corporate sector is able to attract even the middle class. The VHS has been established to serve the underprivileged community and the middle class people living around it on an area concept. But due to development of organised sector on an occupational concept, the VHS finds it difficult to attract clientece from those sectors who are living around it.

7. Low priority to health

In our country health is not a priority. It becomes a priority only if the illness causes considerable amount of

suffering and the poor in the countries have a high threshold for suffering due to our more pressing needs. To-day, people visiting hospitals are bothered about quick attention of their ailments and even quicker cure. It may not be out of place to mention here that the morbidity load in the community at any given point is 94% and 92% of this, is formed by minor ailments.

8. Failure to appreciate value of medical records

The VHS has a laudable objective of developing much needed health information through the evolution of family oriented health records from womb to tomb. Today people visiting hospitals are bothered about quick attention of their ailments and even quicker cure. Nobody else seems to emphasise on the value of records.

9. Paying for health care

For centuries, people have been told that health care will be free. Nothing in the world is free except air and that is polluted. It costs somebody to provide for the health care. While people derive pride in spending for food, clothing and shelter they resent paying for their health. Even those in higher income brackets, do not feel shy to underquote their salaries when it will cost them less than what it would, had they declared their true income. This 'cheating' has become universal with the result, true asessment of income is becoming well neigh impossible. This results in short-fall of the anticipated expenditure. We are of the firm opinion that if the rich and poor alike contribute 0.75% of their annual income, quality primary health care services can be made available to one and all irrespective of their economic status and geographic domicile. The under mentioned plan for 'Community Health Development and Education Combines' of ours still remains on paper for want of seed money for trying it out on an area concept.

It is our dream that all the health expenditure by the Central, State and local bodies organised sectors and voluntary spending should be pooled into a common resource pool and there should be a single uniform channel for providing primary health care services, irrespective of their economic status or geographic domicile. Community contribution should also be pooled into this resource pool. This Community Health and Education Development Combines (COHEDEC) will be totally responsible for the delivery of health services on an area concept. If necessary for mobilising resources, a small health cess may be contemplated.